APPENDIX A
ADDITIONAL GUIDELINES OR SUGGESTED PRACTICES

APPENDIX A-1: FEDERAL INDIAN CHILD WELFARE ACT (ICWA)

A. PUBLIC LAW 95-608, INDIAN CHILD WELFARE ACT OF 1978

1.0 Background

Under this Federal Act, passed in 1968, Indian Tribes were granted extensive jurisdiction in child welfare cases involving Indian children, recognizing "that there is no resource that is more vital to the continued existence and integrity of Indian Tribes than their children."

2.0 Purpose

The ICWA was enacted to prevent the continued removal by state agencies, courts and private agencies of large numbers of Indian children from their families and their culture.

2.1 Overview

The Act "established minimum standards for the removal of Indian children from their families and the placement of such children in foster or adoptive homes which will reflect the unique values of Indian culture."

3.0 Applicable Children

These are all children who have Native American or Alaskan Eskimo, or Aleut heritage of a federally recognized tribe. Federally recognized tribes are listed each year in the Federal Register. Because Virginia has no federally recognized tribes, a child belonging to a Virginia tribe is not currently subject to the Indian Child Welfare Act.

4.0 Responsibilities of Local Department Workers

If such a child belongs to a tribe located outside Virginia, does not live on a recognized reservation (there are no federally recognized tribal reservations in Virginia), and is in imminent danger, the child protective service worker has the authority to exercise summary removal.

a. A local department may temporarily place a child.

b. The local department shall immediately contact the Child Protective Services Unit in the Family Services Division, VDSS Central Office,

Richmond (804-692-1259) before taking any action to place one of these children, other than temporarily.

c. The Child Protective Services Unit shall contact the Bureau of Indian Affairs (Evelyn Roan-Horse or Larry Black at 703-235-2353) on behalf of the local department to determine which tribe, if any, will take jurisdiction of the child, and how this shall occur.

5.0 ICWA Applies to Four Types of Custody Proceedings

The ICWA applies to four types of Indian child custody proceedings, to include foster care placements, termination of certain parental rights, pre-adoption placements, and adoption placements.

6.0 Placing Indian Child in Foster Care

According to the ICWA, when an Indian child is placed in foster care, the placement agency or party must place the child (in the absence of good cause to deviate) with

a. A member of the Indian child's extended family (including non-Indian members of the family);

b. A foster home licensed or approved by the child's tribe;

c. An Indian foster home licensed or approved by a non-Indian agency or authority; or

d. An institution for children that has the approval of an Indian tribe.

7.0 Indian Tribal Courts Maintain Exclusive Jurisdiction over Indian Children Living on Reservations

The ICWA vests Indian tribal courts with exclusive jurisdiction over Indian Children who live on federally recognized Indian reservations.

B. VIRGINIA TRIBES (NOT SUBJECT TO ICWA)

1.0 Treaty of 1677

Virginia tribes are organized as chartered corporations, and their recognition from the state dates to their treaty with the Colony of Virginia in 1677. These tribes are eligible for federal recognition, and it is expected that federal recognition may be granted.

2.0 Federal Funding for Virginia Tribes

Virginia tribes do benefit from federal funds for education and community development the same as do federally recognized tribes.

3.0 Specific Virginia Tribes Recognized by the Commonwealth of Virginia

Virginia tribes include the Chickahominy, Eastern Chickahominy, Mattaponi, Monacan, Nansemond, Pamunkey, Rappahannock, and Upper Mattaponi.

APPENDIX A-2: BATTERED CHILD SYNDROME

Battered Child Syndrome refers to a group of symptoms and behaviors exhibited by a child who has been repeatedly physically abused. Battered Child Syndrome is a medicolegal term describing a diagnosis by a medical expert based on scientific studies that when a child suffers certain types of continuing injuries that those injuries were not caused by accidental means. [1] The battered child syndrome "exists when a child has sustained repeated and/or serious injuries by nonaccidental means." [2]

Obvious physical signs are cuts, bruises, broken bones, or burns. Although all of these injuries can easily be caused by accidents, examinations of battered children usually find that the injuries aren't compatible with the account of the accident. The exam may also reveal evidence of past injuries as well. Often, the perpetrator is careful to avoid areas of the child's body that are open to view such as the head and arms. Subsequently, teachers, friends, and others who come into contact with the child may never suspect there is a problem unless they are aware of specific behaviors commonly exhibited by battered children. Watch for surreptitious or manipulative behavior, limited impulse control, angry outbursts, and poor judgment as to what is safe or unsafe. The child may become withdrawn, use drugs or alcohol, do poorly in school, and seem to have no focus or purpose. [3]

APPENDIX A-3: FAILURE TO THRIVE SYNDROME

A. ORGANIC AND NONORGANIC FAILURE TO THRIVE

Failure to thrive syndrome describes the malnourished and depressed condition of infants, implying not only growth deficits, but also disorders of behavior and development.

1.0 Organic Failure to Thrive

Failure to thrive is used to designate growth failure both as a symptom and as a syndrome. As a symptom, it occurs in patients with a variety of acute or chronic illnesses that are known to interfere with normal nutrient intake, absorption, metabolism, or

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[1] Black's Law Dictionary, 152 (6th ed. 1990).
[2] *Estelle v. McGuire*, 502 U.S. 62 (1991).
[3] UCSO Healthcare, *Health Guide* "Battered Child Syndrome."

excretion, or to result in greater-than-normal energy requirements to sustain or promote growth. In these instances, it is referred to as organic FTT.

2.0 Nonorganic Failure to Thrive

Nonorganic failure to thrive is an interactional disorder in which parental expectations, parental skills, and the resulting home environment are intertwined with the child's developmental capabilities. Since the mother is the primary caretaker in most families, this syndrome has been associated with maternal deprivation (see physical neglect-failure to thrive definition) and/or emotional abuse. Failure to thrive syndrome has been referred to as psychosocial dwarfism disorder. It is characterized by physical and developmental retardation associated with a dysfunctional mother – infant relationship. Nonorganic failure to thrive involves the parents' failure to provide nurturance and attachment to the child.

When the term is used to designate a syndrome, it most commonly refers to growth failure in the infant or child who suffers from environmental neglect or stimulus deprivation. It is then designated nonorganic failure to thrive, indicating the absence of a physiologic disorder sufficient to account for the observed growth deficiency.

3.0 Mixed Etiology

Using the most restrictive definition, only those children who were full-term and normally grown at birth and who, by careful investigation, have no congenital or acquired illness are included in the group designated Nonorganic failure to thrive. Organic failure to thrive and nonorganic failure to thrive are not mutually exclusive. There can be children who have growth failure of mixed etiology. This mixed etiology group includes children who were born prematurely but have evidence of disproportionate growth failure in later infancy; children who have or have had some defect that cannot sufficiently explain the current growth failure (e.g., successful cleft palate repair in the past); and children who are frustrating (e.g., because of a neurologically impaired suck) or extremely aversive (e.g., because of a deformity) to the care giver.

4.0 Inadequate Causes

In failure to thrive of any etiology, the physiologic basis for impaired growth is inadequate nutrition to support weight gain. In nonorganic failure to thrive, lack of food may be due to impoverishment, poor understanding of feeding techniques, improperly prepared formula, or inadequate supply of breast milk.

The psychologic basis for nonorganic failure to thrive appears to be similar to that seen in hospitalism, a syndrome observed in infants kept in sterile environments who suffer from depression secondary to stimulus deprivation. The nonstimulated child becomes depressed, apathetic, and ultimately anorexic. The unavailability of the stimulating person (usually, the mother) may be secondary to that person's own depression, poor

parenting skills, anxiety in or lack of fulfillment from the caretaking role, sense of hostility toward the child, or response to real or perceived external stresses (demands of other children, marital dysfunction, a significant loss, or financial difficulties).

Nonorganic failure to thrive may be considered the result of a disordered interaction between mother and child in which the child's temperament, capacities, and responses help shape maternal nurturance patterns. Failure to thrive is not necessarily the effect of poor care giving by an inadequate or troubled mother. Nonorganic failure to thrive can be the result of a variety of interactional disorders ranging from the severely disturbed or ill child, whose care poses a major challenge to even the most competent parent, to the potentially most undemanding and compliant child being cared for by a mentally ill parent without adequate social, emotional, financial, cognitive, or physical resources. Within these extremes are maternal-child "misfits" in which the demands of the child, although not pathologic, cannot be adequately met by the mother, who might, however, do well with a child of different needs or even with the same child but under different life circumstances.

B. CHARACTERISTICS OF FAILURE TO THRIVE

1.0 Appearance

a. Short stature (height and weight consistently fall fellow the third percentile on the Standard Growth Chart;

b. Unusually thin;

c. Infantile proportions;

d. Potbelly (with episodes of diarrhea);

e. Skin dull, pale, and cold;

f. Limbs pink or purple, cold and mottled;

g. Edema of the feet, legs, hands, and forearms;

h. Poor skin care, excoriations, abrasions, and ulcers;

i. Sparse, dry hair with patches of alopecia (hair loss);

j. Dejection (avoid personal contact) and apathy (avoid eye contact);

k. May have bruises, small cuts, burns or scars (appear to be insensitive to pain and have self inflicted injuries).

2.0 Behavior

a. Passive with or without catatonia;

b. Rocking or head banging;

c. Retarded speech and language;

d. Delayed development;

e. Solitary and unable to play;

f. Insomnia and disrupted sleep;

g. Easily bullied;

h. Gorging food and scavenging from garbage cans, wastebaskets, toilet bowl, or dog/cat dish.

(Note: During their convalescent stay in a hospital, they have marked growth spurts that relapse as soon as they return to their home environment."

3.0 Progress in the Hospital

a. Rapid recover of growth and liveliness;

b. Slower progress with speech and language;

c. Affection seeking, but may be casual or indiscriminate;

d. Attention seeking;

e. Severe tantrums at the slightest frustration;

f. Rocking and head banging when upset;

g. Continues to want to eat and drink more than can reasonably consume and may scavenge food.

4.0 Long-Term Behaviors

a. Speech and language immaturity;

b. Gorging of food that may last six months or more;

c. Restlessness with short attention span;

d. Rocking and head banging if stressed;

e. Difficulties with peer group and learning in school;

f. Soiling and wetting (encopretic and enuretic);

g. Stealing and lying;

h. Tantrums and aggression.

C. INVESTIGATING ALLEGATION INVOLVING SUSPECTED FAILURE TO THRIVE SYNDROME

Nonorganic failure to thrive requires a medical diagnosis. Organic failure to thrive has to be ruled out. During the investigation, the worker should gather as much information as possible about the child and pass it on to the examining physician.

D. BASIS OF MEDICAL DIAGNOSIS

Engaging the parents in the search for the basis of the problem and its treatment is essential and helps to foster their self-esteem. This avoids blaming those who may already feel frustrated or guilty because of an inability to perform the most basic of parental roles—adequate nurturance of their child. The family should be encouraged to visit as often and as long as possible. They should be made to feel welcome and the staff should support their attempts to feed the child, provide toys as well as ideas that promote parent-child play and other interactions, and avoid any comments that state or imply parental inadequacy, irresponsibility, or other fault as the cause of the failure to thrive.

1.0 Child's Growth History

The growth chart, including measurements obtained at birth if possible, should be examined to determine the child's trend in growth rate. Except in severe cases where malnutrition is obvious, the diagnosis of FTT should not be based on a single measurement, because of the wide variations existing in the normal population.

2.0 The Child's Dietary History

A detailed dietary history is essential, including techniques for preparation and feeding of formula or adequacy of breast milk supply, and feeding schedule. Observation of the primary care givers feeding the infant to evaluate their technique as well as the child's vigor of sucking should be undertaken as soon as possible. Easy fatigability may indicate underlying exercise intolerance; enthusiastic burping or rapid rocking during feeding may result in excessive spitting up or even vomiting; disinterest on the part of the care giver

may be a sign of depression or apathy, indicating a psychosocial environment for the infant that is devoid of stimulation and interaction.

An assessment of the child's elimination pattern to determine abnormal losses through urine, stool, or emesis should be undertaken to investigate underlying renal disease, a malabsorption syndrome, pyioric stenosis, or gastroesophageal reflux.

3.0 Past Medical History

Past medical history inquiries should be directed toward evidence of intrauterine growth retardation or prematurity with uncompensated growth delay; of unusual, prolonged, or chronic infection; of neurologic, cardiac, pulmonary, or renal disease; or of possible food intolerance.

4.0 Family History

The family history should include information about familial growth patterns, especially in parents and siblings; the occurrence of diseases known to affect growth (e.g., cystic fibrosis); or recent physical or psychiatric illness that has resulted in the infant's primary care giver being unavailable or unable to provide consistent stimulation and nurturance.

5.0 Social History

The social history should include attention to family composition; socioeconomic status; desire for this pregnancy and acceptance of the child; parental depression; and any stresses such as job changes, family moves, separation, divorce, deaths, or other losses. Infants in large or chaotic families or infants who are unwanted may be relatively neglected because of the demands of other children, life events, or parental apathy; financial difficulties may result in over dilution of formula to "stretch" the meager supply; breast-feeding mothers who are under stress or are poorly nourished themselves may have decreased milk production.

6.0 Physical Examination

Physical examination should include careful observation of the child's interaction with individuals in the environment and evidence of self-stimulatory behaviors (rocking, head banging). Children with Nonorganic FTT have been described as hyper vigilant and wary of close contact with people, preferring interactions with inanimate objects if they are interactive at all. Although Nonorganic FTT is more consistent with neglectful than abusive parenting, the child should be examined carefully for any evidence of abuse. A screening test of developmental level should be performed and followed up with a more sophisticated development assessment if indicated.

Bibliography

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APPENDIX A-4: MUNCHAUSEN SYNDROME BY PROXY

Munchausen syndrome by proxy in adults is "a condition characterized by habitual presentation for hospital treatment of an apparent acute illness, the patient giving a plausible and dramatic history, all of which is false." [4] "Munchausen syndrome by proxy occurs when a parent or guardian falsifies a child's medical history or alters a child's laboratory test or actually causes an illness or injury in a child in order to gain medical attention for the child which may result in innumerable harmful hospital procedures." [5] Munchausen syndrome by proxy involves an apparent deeply caring caretaker who repeatedly fabricates symptoms or provokes actual illnesses in her helpless infant or child.

Maybe the most important aspect of this syndrome is the immense ability of the caretaker to fool doctors and the susceptibility of physicians to that person's manipulations. The hospital, which is the most common setting for Munchausen syndrome by proxy cases, is where as much as 75% of the Munchausen syndrome by proxy related morbidity occurs as a consequence of attempts by physicians to diagnose and treat the affected child or infant. More than 98% of Munchausen syndrome by proxy cases involve female perpetrators.

1.0 Commonly Fabricated Illnesses and Symptoms

The most common fabrications or modes of symptom inducement in Manchausen syndrome by proxy involve seizures, failure to thrive, vomiting and diarrhea, asthma and allergies and infections.

2.0 Indicators for Suspecting and Identifying Munchausen Syndrome by Proxy

A child who has one or more medical problems that do not respond to treatment or that follow an unusual course that is persistent, puzzling and unexplained.

Physical or laboratory findings that are highly unusual, discrepant with history, or physically or clinically impossible.

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[4] Dorland's Illustrated Medical Dictionary 1295 (26th ed. 1981).
[5] Zumwalt & Hirsh, *Pathology of Fatal Child Abuse and Neglect*, Child Abuse and Neglect 276 (R. Helfer & Kempe eds., 4th ed. 1987).

A parent, usually the mother, who appears to be medically knowledgeable and/or fascinated with medical details and hospital gossip, appears to enjoy the hospital environment, and expresses interest in the details of other patients' problems.

A highly attentive parent who is reluctant to leave her child's side and who herself seems to require constant attention.

A parent who appears to be unusually calm in the face of serious difficulties in her child's medical course while being highly supportive and encouraging of the physician, or one who is angry, devalues staff, and demands further intervention, more procedures, second opinions, and transfers to other more sophisticated facilities.

The suspected parent may work in the health care field herself or profess interest in a health-related job.

The signs and symptoms of a child's illness do not occur in the parent's absence (hospitalization and careful monitoring may be necessary to establish this casual relationship).

A family history of similar sibling illness or unexplained sibling illness or death.

A parent with symptoms similar to her child's own medical problems or an illness history that itself is puzzling and unusual.

A suspected parent with an emotionally distant relationship with her spouse; the spouse often fails to visit the patient and has little contact with physicians even when the child is hospitalized with serious illness.

A parent who reports dramatic, negative events, such as house fires, burglaries, car accidents, that affect her and her family while her child is undergoing treatment.

A parent who seems to have an insatiable need for adulation or who makes self-serving efforts at public acknowledgment of her abilities.

Bibliography:

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APPENDIX A-5: SEXUAL ABUSE

The information below is compiled from articles and medical journals listed in the bibliography. The information is not intended to be comprehensive. If further information or clarification is needed consult a physician or the sources listed in the bibliography.

A. Physical Examinations for Possible Sexual Abuse

A normal physical examination is common in child sexual abuse. An absence of physical findings in sexually abused children can be explained in a number of ways. Many types of sexual molestation do not involve penetration and will not leave physical findings. Evidence of ejaculate may not be present if the child has washed, urinated, or defecated and if more than 72 hours has elapsed since the assault. The hymen is elastic and penetration by a finger or penis, especially in an older child, may cause no injury or may only enlarge the hymenal opening. Moreover, injuries can heal rapidly. Hymenal healing occurs in 6 to 30 days and can be complete. Partial hymenal tears can heal as soon as 9 days after injury, while extensive tears may take up to 24 days to heal.

1.0 Medical Categorization of the Physical Examination for Sexual Abuse

Medical professionals commonly will classify the findings of the physical examination into one of four categories:

Category I: Normal Appearing Genitalia. The majority (60% or more) of abused children fall into this category.

Category II: Nonspecific Findings. Abnormalities of the genitalia that could have been caused by sexual abuse but are also seen in girls who are not victims of sexual abuse. Included in this category are redness or inflammation of the external genitalia, increased vascular pattern of the vestibular and labia mucosa, presence of purulent discharge from the vagina, small skin fissures or lacerations in the area of the posterior fourchette, and agglutination of the labia minora. Nonspecific Findings are often seen in children who have not been sexually abused.

Category III: Specific Findings. The presence of one or more abnormalities strongly suggesting sexual abuse. Such findings include recent or healed lacerations of the hymen and vaginal mucosa, hymenal opening of one or more centimeters, proctoepisiotomy (a laceration of the vaginal mucosa extending to involve the rectal mucosa) and indentations on the vulvar skin indicating teeth marks (bite marks). This category also includes patients with laboratory confirmation of a venereal disease (e.g., gonorrhea). Category III is suspicious or highly suspicious for sexual abuse.

Category IV: Definitive Findings. Any presence of sperm or sexually transmitted disease. Category IV is conclusive of sexual abuse, especially with children under 12 years of age. Older children may be sexually active.

2.0 Classification of Physical Findings in Sexual Abuse Examinations

Specific physical findings are strongly indicative of sexual abuse beyond reasonable doubt as follows:

a. Clear-cut tears, fresh or old scars; significant distortion of the normal shape of the hymen and/or hymenal bruising;

b. Lacerations, scars, bruises, and healing abraded areas, often accompanied by neovasularization, of the posterior fourchette;

c. Anal dilation greater than 15 mm transverse diameter with gentle buttock traction with the child in knee-chest position. Large anal scars in the absence of a history that could explain the scars.

C. POSSIBLE PHYSICAL INDICATORS IN SEXUALLY ABUSED GIRLS

Certain types and locations of hymenal injuries are often seen after sexual abuse. The hymenal membrane at its midline (6 o'clock position) attachment along the posterior rim of the introitus, during actual or attempted penetration, is the portion of the hymen most likely to be damaged. A narrowed (attenuated) hymen at this position is usually indicative of an injury. Mounds, projections, or notches on the edge of the hymen and the exposure of intravaginal ridges increase the possibility of abuse. Generally, attempted forced vaginal penetration results in hymenal tears and fissures between the 3 and 9 o'clock positions and may extend across the vestibule and fourchette. Other physical signs indicating abuse include:

1.0 Erythema, Inflammation, and Increased Vascularity

In sexual abuse cases, redness of the skin or mucous membranes due to congestion of the capillaries. Normal vaginal mucosa has a pale pink coloration.

2.0 Increased Friability

A small dehiscence (or breakdown) of the tissues of the posterior fourchette may be precipitated by the examination, with occasional oozing of blood. This is usually associated with labial adhesions. When the adherent area is large, greater than 2 mm, the suspicion of abuse should be greater.

3.0 Angulation of the Hymenal Edge

There may be V-shaped or angular configuration of the edge of the hymen. The hymenal edge should be smooth and round. Angulation often marks a healed old injury.

4.0 Labial Adhesions

Although labial adhesions are a nonspecific finding often seen in girls with no history of sexual abuse, they may also be a manifestation of chronic irritation and can be seen in children who have been abused.

5.0 Urethral Dilation

Urethral dilation may be an abnormal physical finding in sexually abused girls. Mild to moderate urethral dilation is probably normal, although higher grades may be considered a manifestation of sexual abuse, probably the result of digital manipulation of the urethral orifice.

6.0 Hymenal or Vaginal Tear

Deep breaks in the mucosa of the vagina and hymen are referred to as tears. These injuries can be seen with accidental injuries as well as with abuse. Often they occur when a history of impaling is given.

Genital injuries should be considered abuse until proven otherwise. The bony pelvis and labia usually protects the hymen from accidental injury. Straddle injuries from falls onto a pointed object, the object rarely penetrates through the hymenal orifice into the vagina. A violent stretching injury, as seen when a child does a sudden, forceful split on a slippery surface, can cause midline lacerations. These injuries can also be caused during sexual abuse by forceful, sudden abduction of the legs.

7.0 Discharge

Vaginal secretions are of various consistencies, colors and odors. The usual cause of vaginal discharge in a nonspecific vaginitis. Nonspecific vaginitis is seen most often in children between 2 and 7 years of age. Some genital discharges are not caused by infection or inflammation. The signs of nonspecific vaginitis are vaginal inflammation and discharge. The child may or may not have symptoms. The only complaint may be a yellowish stain on the child's underpants noticed by the mother. The character of the discharge, the appearance of the vaginal mucosa, and the child's symptoms do not help to identify the etiologic agent or the type of bacterial causing the infection.

8.0 Fissures

Superficial breaks in the skin or mucous membranes fissures may ooze blood and be painful. They heal completely and leave no sequelae unless they become infected in which case they may result in a small scar or an anal tag.

9.0 New or Healed Lacerations

Lacerations are deep breaks in the skin or mucous membranes of the vagina or anus. They often leave scar formation after healing.

10.0 Enlarged Hymenal Introital Opening

One criterion often used to make a diagnosis of sexual abuse is an enlargement of hymenal introital opening. A vaginal introital diameter of greater than 4 mm is highly associated with sexual contact in children les than 13 years of age. The size of the hymenal opening can vary with increasing age and pubertal development of the child. Other factors such as the position of the child during the measurement, the degree of traction placed on the external genitalia, and the degree of relaxation of the child can influence the measurements. The nature of the abuse and the time elapsed since the abuse can also change genital findings.

11.0 Sexually Transmitted Diseases

Transmission of sexually transmitted diseases outside the perinatal period by nonsexual means is rare. Gonorrhea or syphilis infections are diagnostic of sexual abuse after perinatal transmission has been ruled out. Herpes type 2, Chlamydia, Trichomoniasis, and condyloma infections are extremely unlikely to be due to anything but abuse, particularly in children beyond infancy.

12.0 Sperm

If the abuse occurred within 72 hours, the physical examination may reveal the presence of sperm. The survival time of sperm is shortened in prepubertal girls because they lack cervical mucus; if there is a delay before an examination, the likelihood of finding sperm is diminished.

D. PHYSICAL FINDINGS ASSOCIATED WITH ANAL SEXUAL ABUSE

Anal assaults comprise a significant proportion of child sexual abuse attacks. Genital injuries or abnormalities are more often recognized as possible signs of abuse, while anal and perianal injuries may be dismissed as being associated with common bowel disorders such as constipation or diarrhea. The anal sphincter is pliant and, with care and lubrication, can easily allow passage of a penis or an object of comparable diameter without injury. The anal sphincter and anal canal are elastic and allow for dilation. Digital penetration usually does not leave a tear of the anal mucosa or sphincter. Penetration by a larger object may result in injury varying from a little swelling of the anal verge to gross tearing of the sphincter. If lubrication is used and the sphincter is relaxed, it is possible that no physical evidence will be found. Even penetration by an adult penis can occur without significant injury. After penetration, sphincter laxity,

swelling, and small mucosal tears of the anal verge may be observed as well as sphincter spasm. Within a few days the swelling subsides and the mucosal tears heal. Skin tags can form as a result of the tears. Repeated anal penetration over a long period may cause a loose anal sphincter and an enlarged opening. Physical indicators of anal sexual abuse include, but are not limited to,

1.0 Perianal Erythema

Reddening of the skin overlying the perineum as well as the inner aspects of the thighs and labia generally indicates that there has been intra crural intercourse (penis between legs and laid along the perineum). Erythema in this area, however, also results from diaper rash, poor hygiene, or after scratching and irritation from pinworms.

2.0 Swelling of the Perineal Tissues

Circumferential perianal swelling appears as a thickened ring around the anus and has been called the tire sign. It is an acute sign and can reflect traumatic edema.

3.0 Fissures

Breaks in the skin/mucosal covering of the rectum, anus, anal skin occur as a result of overstretching and frictional force exerted on the tissues. This can occur following passage of a hard stool or abusive traumatic penetration of the anus. Tiny superficial cracks in the verge or perianal skin often result from scratching with pinworms or with excoriation from acute diarrhea or diaper rash.

4.0 Large Tears

Large breaks in the skin extending into the anal canal or across the perineum are usually painful and can cause anal spasm. Tears often heal with scarring and leave a skin tag at the site of the trauma.

5.0 Skin Changes

Repeated acts of penetration will lead to changes in the anal verge skin. Repeated friction and stretching of the fibers of the corrugated cutis and muscle results in thickening and smoothing away of the anal skin folds. The skin appears smooth, pink, and shiny, with a loss of normal fold pattern. The presence of these skin changes suggests chronicity of abuse. Scars are evidence of earlier trauma.

6.0 Funneling

Funneling is a traditional sign of chronic anal sexual abuse but its presence in children has been questioned. The appearance of funneling or a hollowing-out of the perianal area is caused by loss of fat tissue or fat atrophy of the subcutaneious area. Although this is

often associated with chronic anal sex, it has also been described to occur in nonabused children.

7.0 Hematoma and/or Bruising

Subcutaneous accumulations of old and new blood and bruising are strong indicators of trauma. It would be very unlikely for these to occur without a history to explain them. These injuries are not likely to be accidental.

8.0 Anal Warts

Anal warts can occur as an isolated physical finding or in conjunction with other signs consistent with abuse, either anal or genital. Anal warts in children under age 2 years whose mother has a history of genital warts are most likely not the result of abuse. If no history of genital warts is elicited, the family should be evaluated for their presence. In children over 4 years of age with new genital warts, abuse should be considered and the child carefully interviewed by an experienced evaluator. Evaluation of genital warts is difficult in the nonverbal child.

9.0 Physical Findings & Abnormalities Mistaken for Anal Sexual Abuse

Perianal abnormalities are often seen in children with Crohn disease or Hirschsprung disease. The anal canal gapes in children with significant constipation. The distended rectum, with a normal anorectal reflex, initiates the gaping. Stool is often seen in the anal canal. Small fissures can also be seen. These children may have trouble with fecal soiling, which causes reddening of the perianal area. Unfortunately, children who were anally abused often suffer from functional constipation, which results in a damaged anal sphincter and fecal soiling. The pain and injury that follow the anal assault may cause spasm of the sphincter and result in functional constipation.

E. CONDITIONS THAT CAN BE MISTAKEN FOR SEXUAL ABUSE

- Lichen scierosis et atrophicus
- Accidental straddle injuries
- Accidental impaling injuries
- Nonspecific vulvovaginitis and proctitis
- Group A streptococcal vaginitis and proctitis
- Diaper dermatitis
- Foreign bodies
- Lower extremity girdle paralysis as in myelomeningocele
- Defects which cause chronic constipation, Hirschprung disease, anteriorly displaced anus
- Chronic gastrointestinal disease, Crohn disease
- Labial adhesions
- Anal fissures

Some dermatologic, congenital, traumatic, and infectious physical findings can be mistaken for sexual abuse. The most common dermatologic condition confused with trauma from sexual assault is lichen sclerosis. It can present in a variety of ways from mild irritation of the labia and vaginal mucosa to dramatic findings such as subepidermal hemorrhages of the genital or anal area involving the labia and vaginal mucosa and/or the anus. Monteleone, J., & Brodeur, A. Child Maltreatment: A Clinical Guide and Reference, 159 (G.W. Medical Publishing 1994).

E. COMMON QUESTIONS & ISSUES

These questions and answers are taken from Monteleone, J., & Brodeur, A. Child Maltreatment: A Clinical Guide and Reference, 159 (G.W. Medical Publishing 1994).

Can a child be born without a hymen to explain physical findings described?

There is no documented case of an infant girl born without a hymen.

Can excessive masturbation or the use of tampons explain abnormal vaginal findings?

Masturbation and tampons do not cause injury to the hymen or internal genital structures. There is no evidence that use of tampons causes trauma to the hymen. Masturbation in girls usually involves clitoral or labial stimulation and does not cause hymenal injury. Children who masturbate excessively or insert foreign objects into body orifices usually show no genital or anal injuries.

Can a child contract a sexually transmitted disease by merely sharing the same bed, toilet seat or towel with an infected individual?

In general, as the title implies, sexually transmitted diseases are sexually transmitted.

Can horseback riding, gymnastics or dancing cause permanent genital changes?

Injuries can occur with physical activities. When such injuries involve the genitalia, the event is very dramatic and will be reported immediately. If a physician finds hymenal changes after a child has disclosed sexual abuse or during a routine examination, injury from one of these activities is not being investigated because it would not be a reasonable explanation for the changes.

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APPENDIX A-6: ISSUES TO CONSIDER WHEN IDENTIFYING A CARETAKER

In determining whether a person is a caretaker, it may be helpful to consider several questions:

> What is the person's relationship with the child?
> What is that person's role or function toward the child?
> Was the primary responsibility of the person toward the child one of supervision and providing care, or was the person providing a professional or expert service?
> How do the child and the child's usual caretaker view this relationship and role?
> How does the community view this relationship and role?
> Have the parents or other person specifically delegated formally or informally the caretaking role for this person?

Practice in some communities has been to exclude some types of persons as caretakers based on the needs of the children, the abilities of families to protect them, and other remedies in place such as a professional licensing board. Some exclusions have included sheriffs, police, doctors, dentists and psychotherapists. Non-public school teachers, coaches, music teachers, etc., have also been unofficially and routinely excluded from the definition of caretaker in some locales.

Frequently there are concerns when the alleged abuser is a minor. The following considerations may guide the decisions regarding a minor as caretaker and alleged abuser:

1. *Was it appropriate for the juvenile to have been put in a caretaking role? Was the supervision plan appropriate?*
2. *Was the alleged abuse by the minor indicative of his/her own abuse? (i.e. sexual knowledge or behavior that is age inappropriate)*
3. *What is the age difference between the alleged abuser and the victim; was this peer interaction?*
4. *What is the minor's understanding of what he did; does he realize how inappropriate it was?*
5. *Is this acting out rather than abusive behavior?*

Special consideration must be given to the needs of minor caretakers who are abusive. The report may be Unfounded in relation to the minor as the abuser, because it is determined that the minor was inappropriately placed in a caretaking role. However, the behaviors of the minor may indicate a need for services.

Each local department maintains the discretion to validate reports of child abuse and neglect.

APPENDIX A-7: SUGGESTED PRACTICES WHEN AUDIO TAPING AN INTERVIEW WITH A CHILD: INCLUDING STORAGE, RETENTION, DUPLICATION AND EDITING AUDIO TAPES

1.0 CPS Worker's Immediate Objectives

In order to accomplish the task of audio taping, the worker should always remember to be patient, observant, flexible and a good listener during the interview with a child. In conducting an audio taped interview with a victim child, the following goals may be met:

a. Minimize trauma to the child
b. Maximize the amount and quality of the information obtained while minimizing any contamination of that information
c. Maintain the integrity of the investigation process for the agencies involved.

2.0 General Operating Procedure & Equipment

The worker, before each interview with the subject child, should ensure the audio taping equipment is in operating order.

a. A new tape is to be used for each incident investigated.

b. The worker may record more than one interview with the subject child on the tape; however, care needs to be taken to leave sufficient space between each interview.

c. If the investigation involves more than one child, each child shall have his own tape. Each tape should be labeled and identified by the child's name, the date of the complaint, complaint number, the worker's name, location of the interview, and show the dates of all interviews included on the tape.

d. Whenever possible, the worker should note the location on the tape of information related to identification of the complainant. This can be done by looking at the number on the tape counter on the tape recorder.

3.0 Pre-Interview Information Gathering

Prior to conducting the interview, the worker should gain as much information about the child and the alleged incident as possible. The worker should know the child's age, verbal skills, developmental level, and vocabulary. For example, if the allegation is sexual abuse, the worker should know if the child has any prior founded reports of sexual abuse and what are the names the child uses to describe body parts. Never assume that you know what a child means by the use of a particular word. Always ask if the meaning is not obvious. Make certain that you are using words and concepts which the child understands.

4.0 Location of Interview

Determine the location of the interview. It is preferable to interview the child in a neutral setting that provides privacy and no inward or outward stimuli or cause for interruption. However, there may be no opportunity when dealing with an emergency situation to have all these elements in place. Should the worker be faced with this, every effort should be made to incorporate as many of the above elements as possible.

5.0 Prepare Questions

Given the time allowed, the worker should plan the interview and write down some of the questions that he/she wants to ask the child.

6.0 Who may be Present for the Interview

a. The worker has the authority to determine who is to be present during the interview.

b. If an interview room is equipped with a two-way mirror or a video monitor, the worker may permit a parent, guardian, or therapist to observe the interview. Be sure that support is given to the parent(s) observing the interview.

c. If the worker is investigating with a law enforcement officer, a decision should be made prior to conducting the interview who will be the lead

interviewer. The person not interviewing may, instead, operate the tape recorder.

d. It is preferable if a joint investigation is no being conducted, that only the child and the worker be present at the interview; however, should the child's comfort depend on another person being present in the room during the interview, the worker should impress on the person the importance of not interfering with the interview.

e. All persons observing the interview should remain silent. Observers present in the room should be seated out of the visual site of the child. Observers be advised that they may hear information that could illicit a non-verbal reaction and that it is essential they show no reaction at all as it could contaminate the interview.

7.0 The Interviewing Worker Needs to be Aware of Circumstances

a. The CPS worker should also be aware of their own reactions.

b. The CPS worker should always be aware of the child's physical needs and capabilities such as:

(1) Attention span
(2) Nutritional requirements
(3) Body functions

For example, do not try to conduct the interview with a young child when they would normally nap or when it is time for them to eat.

c. It is okay to allow the young child to draw, play with a toy, move about the room, etc. while the interview occurs.

d. The CPS worker should always keep in mind that this is a fact finding interview not a therapeutic one, yet that does not mean the investigative interview needs to be a traumatic experience.

8.0 Beginning the Recording of the Interview

a. After the recording device has been turned on, the interviewer should state the date, time, location, and names of those present in the room.

b. The CPS worker should explain his/her role to the child and the role of anyone else present in the room and state the purpose of the interview.

c. The worker should then engage the child in general conversation asking him to state his name and age. The worker may ask the child to talk about his favorite subject in school, a favorite hobby, or how they like to spend their free time. Have him describe a favorite event, i.e., last birthday or special trip. Here is where it is important to be flexible and know the child you are interviewing. For instance, if you are interviewing an older child, they may want to minimize this stage and get straight into the discussion of the allegation.

9.0 General Interviewing Questions & Techniques

a. If I misunderstand something you say, please tell me. I want to know. I want to get it right.

b. If you don't understand something I say, please tell me and I will try again.

c. If you feel uncomfortable at any time, please tell me or show me the stop sign (determine what that is to be).

d. Even if you think I already know something, please tell me anyway.

e. If you are not sure about an answer, please do not guess. Tell me you're not sure before you say it.

f. Please remember when you are describing something to me that I was not there when it happened. The more you can tell me about what happened, the more I will understand what happened.

g. Please remember that I will not get angry or upset with you.

h. Only talk about things that are true and really happened.

i. Stress that you, the interviewer, will follow these rules.

10.0 Determine the Child's Capacity for Truthfulness

The worker needs to determine the child's concept of telling the truth and lies. The worker should ask the child to describe the meaning of truth and the consequences of telling lies. If the child clearly does not have the concepts of truths and lies, the worker should continue the interview, but with caution.

11.0 Initiate Free Narrative

Introduce the topic of concern asking open-ended questions allowing the child to talk in a free narrative. Allow the child to go at their own pace. Do not interrupt the child. The child may be prompted by the worker by asking: "What happened next?" or "You were saying—relate the last thing they were saying." Do not interrupt the child no matter how verbose or inconsistent the story.

12.0 Ask Open-Ended Questions

After the child has exhausted his/her free narrative for one incident the worker may begin to ask open-ended questions. This will enable the worker to assist the child in recalling more details. If the child discloses a new incident, the worker should again allow the child to talk in the free narrative style about the new incident. Then begin the process of the open-ended questions again. An example of an open-ended question is: Do you remember any more about the time it happened in the kitchen?

When the worker is asking open questions, it is absolutely imperative that the child knows that, "I don't remember" is an acceptable answer.

13.0 Keep Track of Multiple Incidents or Allegations

Should the child disclose several incidents of abuse the worker may want to label them so that the worker can refer the child back to them in order to get more detail. (Labeling incidents should become readily apparent for example where the incident occurred may provide a label, i.e., the kitchen incident or the park incident.)

14.0 Use Specific Questions

The CPS worker may use specific questions. This would clarify and extend previous answers. This form of questioning is used when previous types of questioning has not resulted in getting sufficient information to assess the credibility of the allegations.

15.0 Avoid Multiple Choice Questions

The CPS worker should avoid multiple choice questions, but if you must use this type of question, include more than two choices. For example, did the park incident happen in the fall, winter, spring, or summer?

16.0 Avoid Using Other Sources When Asking Questions

The CPS worker should never include information he/she has obtained from another source. For example, do not begin a question with, "I understand from your mother that your Uncle Sam took some pictures of you." If you have been informed that the child was photographed, yet that information has not been forthcoming in the child's free narrative or during open questioning, you may ask, "Do you remember anything about some pictures?"

17.0 Address Inconsistencies Toward End of Interview

The CPS worker should address any inconsistencies in the child's statement toward the end of the interview. This is an area of questioning that should be approached cautiously and gently. If the child displayed language and/or knowledge that seems inappropriate for their age, this would be the time to determine where the child learned that knowledge of those words.

18.0 Ending the Interview

The worker should ask the child if he/she has any questions. The worker should explain to the child what will happen next in the investigation process.

19.0 Storing Audio Tapes

a. Once the audio tape has been made, the worker should ensure it is properly labeled, as indicated earlier, then place the tape in an envelope, label the envelope with the case name, seal the envelope, and secure it to the case record.

b. Tapes are to be stored in the case record for the same length of time as CPS policy requires for other case documentation. For example, in unfounded cases, tapes must be retained for one year from the complaint date. Tapes are required to be retained for longer periods in founded cases. (Level 3 – three years, Level 2 – seven years, and Level 1 – 18 years).

20.0 Who Can Receive Copies of the Taped Interviews?

a. Interviews with the victim child can only be released during the appeals process. If a copy of the audio tape is needed, based on CPS policy governing the release of information during the appeal process, it must be determined if any statutorily protected information is contained on the tape. If so, a duplicate tape will be needed. (The original tape must never be redacted.) Identification of the area(s) to be edited, indicated by tape counter number(s), must be provided to the entity copying the tape. As an option, the local department may wish to type a transcript of the tape. This is not a requirement, however.

b. Audio taped interviews with the alleged abuser can be duplicated by the local department by playing the audio tape on one tape recorder while recording the tape on a second tape recorder. Local departments also have the option of typing a transcript of the interview.

21.0 Redacting/Editing Sensitive Information from a Tape

The Department is investigating the option of entering into a contract with a professional service to copy and/or redact (edit) audio tapes. Should this occur, procedures will be developed and distributed to all local agencies. Until that time, the local agency is responsible for the editing of duplicate tapes. The original tape must never be edited. The worker is the most knowledgeable about the content of the tape and is therefore the most logical individual to edit the duplicate tape.

22.0 Reuse of Audio Tapes

Audio tapes are never to be reused. This would potentially compromise the tape being reused by possibly having the earlier interview "bleed through" on the next interview. It would also pose a privacy protection issue by having confidential tapes available for further use.

23.0 Destruction of Used Tapes

Once the length of time has passed for retaining the case record, from one to 18 years, depending on the disposition of the investigation, the audio tape(s) must be destroyed. A tape eraser box will be provided to each agency in order for tapes to be erased. Once erased, the tape cassettes should be broken, or the tape cut in order to ensure the complete eradication of information on the tape. Some tape recorders have an 'erase' feature that will void the information on the tape. This should be tested, however, to ensure it is actually erasing the tape.

APPENDIX A-8: HOW TO PROCEED WITH INVESTIGATION WHEN INITIAL ENTRY INTO THE HOME IS DENIED

1.0 Authority

The worker has the authority to enter the home if permitted to enter by a person who resides in the home.

2.0 Alleviate Fear, Anxiety, Anger

The CPS worker should try to alleviate the fear and anxiety of the occupant, and/or defuse any anger. It is not appropriate to engage in a power struggle.

3.0 Alternatives to Immediate Entry

Should the CPS worker be denied entry, the CPS worker has several options:

a. The CPS worker may suggest the occupant speak with them on the porch, deck, or in the yard, or even through the door, while at the same time

acknowledging the feelings of the occupant (anger, fear, suspicion) in his reluctance to allow entry.

b. The CPS worker may explain the law and the parameter of their responsibilities and mandates, and ask the occupant how the CPS worker may alleviate the skepticism or fear of the occupant so that then or in the future the CPS worker may be allowed to enter.

c. The CPS worker may invite the occupant and any person of his choice (including an attorney) to meet with him first at the local DSS office, to further explain the CPS system.

d. The CPS worker may suggest a first meeting at a neutral spot, such as a local fast-food restaurant, or other public place.

e. The CPS worker may suggest a first meeting at a friend or family member's home, or a meeting in the occupant's home when a friend, neighbor or family member is present.

f. The CPS worker may suggest mediation with the occupant to negotiate entry.

g. The CPS worker may contact his supervisor for direction.

h. The CPS worker may follow-up a denial of entry with a letter citing the Virginia Code responsibilities.

APPENDIX A-9 GUIDELINES FOR INVESTIGATIONS OF SCHOOL PERSONNEL

The following procedures have been reviewed by both the Department of Education and the Department of Social Services and are recommended. They are offered as a recommended model for handling child protective services reports. The model should be adapted to meet local needs.

SECTION I – REPORTING CHILD ABUSE AND NEGLECT BY SCHOOL EMPLOYEES

A. Responsibilities of Local School Employees

1. According to Virginia state law, any teacher or other person employed in a public school is a mandated reporter.

2. As such, any teacher or other person employed in a public school is required to report all instances of suspected abuse and neglect of children under age 18 to local departments of social services.

3. When reporting child abuse or neglect, the local school employee must share with the local department of social services all information which establishes the basis for the suspicion of abuse or neglect of the alleged victim child.

4. Each school should have a designated contact person to whom all reports from school staff on suspected child abuse or neglect will be made. A back-up person should also be designated.

5. When reports of suspected child abuse or neglect are received from school staff by the contact person, the contact person will immediately transmit the report to the local department of social services or to the State Hotline (1-800-552-7096). The obligation of the designated contact person to report cases of suspected child abuse or neglect brought to his attention by staff members is not discretionary and the contact person shall assure that the case is duly reported.

6. If a complainant believes that a delay resulting from following these procedures would be detrimental to the child, he may report this case directly and then inform the designated contact person of his referral.

B. Responsibilities of Local Departments of Social Services

1. Local departments of social services shall have the capability of receiving reports on a 24-hours-a-day, 7-day-a-week basis.

2. Local departments of social services shall provide information and cooperate in training the local school division personnel regarding their responsibilities to report suspected child abuse or neglect, methods of reporting suspected incidents, and the role and functions of the local departments of social services in child abuse and neglect.

SECTION III – INVESTIGATIONS OF CHILD ABUSE AND NEGLECT WHEN THE CHILD IS ALLEGED TO HAVE BEEN ABUSED/NEGLECTED IN AN IN-HOME SETTING

A. Responsibilities of Local School Divisions

1. The school shall allow the local child protective services worker to interview the child or siblings without consent of parent/guardian. The interview shall be in private, without the presence of school personnel, in order to protect the family's right to privacy.

2. The local school division shall cooperate with the needs of the CPS

worker, and provide the following resources, as appropriate:

a. Room/private space for interviews of child(ren);

b. Pertinent records such as home and work phone numbers of child's parents/guardians and home address for child(ren).

B. Responsibilities of Local Departments of Social Services

1. Upon receipt of the complaint, the local social services department will conduct an immediate investigation. The local child protective services worker assigned to investigate will contact the designated school contact person to arrange, if necessary, for:

   a. Securing further information in regard to the complaint;

   b. Obtaining records and/or documentation relative to the complaint on which may be the basis for the complaint;

   c. Child's home address and work and home telephone numbers of his parents or guardians.

   d. Arrangements to see and interview the child at school when necessary.

2. If the investigation requires the CPS worker to go onto school premises, the local CPS worker shall inform the site administrator or designee of the need for private space to interview the victim child.

3. The CPS worker shall complete the investigation and make a disposition with 45 (or 60 days when an extension is documented to be necessary), unless the alleged abuser waives these time frames.

4. If the initial report was made by a school employee, that individual shall receive a written communication from the local department of social services informing him that the investigation has been completed, and either that the disposition was "Unfounded," or that "Appropriate action has been taken."

SECTION IV - INVESTIGATIONS OF CHILD ABUSE AND NEGLECT WHEN THE CHILD IS ALLEGED TO HAVE BEEN ABUSED/NEGLECTED BY A SCHOOL EMPLOYEE

A. Responsibilities of Local School Divisions

1. The local school site administrator, or designee, if there is no conflict of interest, may participate in the planning of the investigation when the report names a school employee as the alleged abuser or neglector.

2. If the investigation involves a school employee as the alleged abuser, the local school division shall cooperate with the needs of the CPS worker, and provide the following resources, as appropriate:
    a. Room/private space for interviews of staff and children;
    b. Accompaniment to the site of the alleged abuse;
    c. Pertinent policies, procedures and records;
    d. Names, functions, and roles of involved parties;
    e. Work schedules of staff;
    f. Phone numbers of collateral children's parents/guardians in order for the CPS worker to gain permission to interview them.

3. Allow the local CPS worker to interview the alleged victim child and siblings in private, without the presence of school personnel, in order to protect the family's right to privacy.

B. Responsibilities of Local Departments of Social Services

1. Conduct an immediate investigation upon receiving a report about suspected incidents of child abuse or neglect.

2. If the investigation requires the CPS worker to go onto school premises, the local CPS worker shall inform the site administrator or designee of the allegations being investigated, the subjects named in the report [alleged abuser and alleged victim child(ren)], and the CPS role and expectations, including private space to interview the victim child.

3. If the investigation involves a school employee as the alleged abuser, and if there is no conflict of interest, the CPS worker shall invite the site administrator or designee to participate in the planning of a joint investigation.

4. If the investigation involves a school employee as the alleged abuser, the CPS worker must request from the administrator the following resources, as appropriate:
    a) Room/private space for interviews of staff and children;
    b) Accompaniment to the site of the alleged abuse;
    c) Pertinent policies, procedures and records;
    d) Names, functions, and roles of involved parties;
    e) Work schedules of staff;
    f) Phone numbers of collateral children's parents/guardians in order to gain permission for the CPS worker to interview them.

5. If the investigation involves a school employee as the alleged abuser, the CPS worker shall interview the alleged abuser according to a plan developed jointly with the facility administrator or designee. Where there is an apparent conflict of interest, the CPS worker shall use discretion regarding who is to be present in the interview.

6. If the investigation involves a school employee as the alleged abuser, the CPS worker shall inform the alleged abuser that he has the right to involve a representative of his choice to be present during the interviews. The CPS worker should also inform him if anyone other than the CPS worker is planning to be present.

7. If the investigation involves a school employee as the alleged abuser, the CPS worker shall provide him the allegations in writing, and offer to tape record the interview, and provide a copy to the alleged abuser at the earliest convenience.

8. If the investigation involves a school employee as the alleged abuser, the CPS worker shall interview collateral staff witnesses, as appropriate, according to a plan developed jointly with the facility administrator or designee. Where there is an apparent conflict of interest, the CPS worker shall use discretion regarding who is to be present in the interview.

9. If the investigation involves a school employee as the alleged abuser, the CPS worker shall keep the facility administrator or designee apprised of the progress of the investigation on an ongoing basis until the investigation is completed.

10. The CPS worker shall complete the investigation and make a disposition with 45 (or 60 days when an extension is documented to be necessary), unless the alleged abuser waives these time frames.

11. If the investigation involves a school employee as the alleged abuser, when the investigation is completed and a disposition is made, the CPS worker shall verbally notify both the alleged abuser and the facility administrator. The alleged abuser should be informed first, or at the same time as the administrator or designee.

12. If the investigation involves a school employee as the alleged abuser, a written report of the findings shall be submitted to the facility administrator, with a copy to the school's Superintendent, and with a copy to the alleged abuser along with his disposition notification letter and appeal notification. This report of findings shall include a summary

of the investigation, with an explanation of how the information gathered supports the disposition.

13. The local department of social services shall inform the parent or guardian or agency holding custody of the victim child written notification of the disposition, with a verbal follow-up. The CPS worker may use discretion in determining the extent of investigative findings to share with the parent; however, sufficient detail must be provided for the child's custodian to know what happened to his child, to make plans for the child, and to provide needed support and services.

14. If the initial report was made by a school employee, that individual shall receive a written communication from the local department of social services informing him that the investigation has been completed, and either that the disposition was "Unfounded," or that "Appropriate action has been taken."

SECTION V - FOLLOW-UP TO THE INVESTIGATION

A. The local department of social services may provide post-investigative protective and/or treatment services, and follow-up contacts to the child, family and named abuser.

B. When a school employee is named as the abuser, the local school division may provide post-investigation corrective action, as deemed appropriate by the school, for the school facility and any personnel, including the named abuser.

IV. CONFIDENTIALITY

A. Information shall be shared between appropriate staff of local departments of social services and local school divisions which is accurate, complete, timely and pertinent so as to assure fairness in determination of the disposition of the complaint.

B. Appropriate precautions shall be taken by both local entities to safeguard the information maintained as a result of the investigation in accordance with the Department of Social Services' confidentiality laws governing child abuse and neglect investigations, except that information obtained from local school division shall be safeguarded in accordance with the confidentiality regulations which govern such information.

APPENDIX A-10 GUIDELINES FOR INVESTIGATIONS WHERE CHILDREN ARE ALLEGED TO BE PRESENT DURING THE SALE OR MANUFACTURE OF DRUGS

The intent of adding a clause to the definition of physical abuse, which was enacted by the General Assembly 2004, is to give recognition to the danger for children when a caretaker exposes the child to the manufacture or sale of drugs. The additional language in the definition references Schedule I & II controlled substances, which include, but are not limited to heroin, cocaine, and methamphetamines. Appendix A-11 provides a coy of Schedules I & II.

There is reason to be concerned about both the safety of the child and the CPS worker when there is the possibility that a "meth lab" is on the premises. The vapors may attack mucous membranes and some chemicals may react with water or other chemicals to cause a fire or explosion.

Since these situations may be dangerous, it is imperative that the local department of social services collaborate with local law enforcement and emergency services. CPS should not be the first on the scene if there is reason to believe someone may be manufacturing drugs on the premises. The following is a sample protocol developed by a locality in North Carolina that has experienced a large number of "meth lab" situations. It is offered for your consideration in developing your own local protocol.

Response Protocol For Children Found In Clandestine Drug Lab Situations Adopted by the Watauga County (North Carolina) Drug Endangered Child Program on April 2, 2004

1. *In the event that a Clandestine Lab is about to be raided and there is a possibility of children in the residence law-enforcement will contact the Watauga County Department of Social Services to begin preparations for responding to the scene if children are found.*

2. *Watauga County DSS will place two social workers on standby prepared to respond to the scene if a lab is found and children are present.*

3. *After law-enforcement verifies a lab is found in a residence and children are present they will then contact Watauga County DSS to respond to the scene. Watauga County DSS will respond immediately.*

4. *Watauga County DSS will contact the Watauga County Fire Marshal's Office to report to the scene to assist in assessing for the need of on-site decontamination of the children.*

5. *The Watauga County Fire Marshal and Watauga County DSS will determine if decontamination on scene is needed by using The Decontamination Field Assessment.*

   5A. If decontamination is needed on the scene for the children the Watauga County Fire Marshal will coordinate the needed procedures based on where the scene is in the county.

6. *If decontamination is needed on scene and possibly if not needed Watauga County DSS will provide a change of clothes for the child.*

7. *Watauga County DSS will make a determination of whether a child needs to be placed into protective custody or if a placement with a safety agreement can be used.*

   7A. Placement in the home where a lab was found cannot occur under any circumstance until the home is cleaned, tested, and decontaminated using State prepared guidelines.

   7B. The child will not be allowed to have contact with any item that was in the home where a meth lab was found due to contamination concerns.

8. *After decontamination has been assessed or done the child will be transported to Watauga Medical Center for evaluation. Watauga County Medical Center requires decontamination at the emergency room prior to the child entering the hospital. Transportation will be provided either by Watauga County DSS, relative, or EMS (if there is a medical concern). The transportation concern will be assessed on a case-by-case basis.*

   8A. If the child is located at the scene and has been in the home within the past 72 hours or is displaying medical concerns the child does need to be taken to Watauga Medical Center for first or secondary decontamination and evaluation.

   8B. If the child has not been in the home where the meth lab was located within the past 72 hours the child can be taken to their pediatrician for evaluation. 8B would be used in cases where the child was not found at the scene but was known to be living there and cases where the child has been out of the home for 72 hours. Also, 8B would be used in cases where children were found to be in the home with the lab but were unknown at the time the meth lab was found and 72 hours is passed.

   8C. Someone with legal custody must be present at the emergency room or pediatrician office to sign for medical checks to be done. If parents are arrested then DSS may have to take custody to authorize medical evaluations.

9. *Watauga County DSS will provide the physician at the Medical Center being used with a copy of the Medical Protocol developed by the Drug Endangered Child Program.*

   9A. Social Workers will need to make sure they get a copy of the Medical Protocol back after evaluations have completed. With each test that has been completed document the form. This is done so that social workers can provide information at the follow-up evaluations as to what testing was done for comparison data.

   9B. All drug testing evidence will follow the chain of custody between physician/medical office and the drug testing lab they use.

10. *After the child is released from the medical center the following steps will take place:*

    10A. If DSS is not taking custody and using a Safety Plan a social worker will need to go to the placement resource and conduct the Kinship Care Assessment before allowing the child to stay there. This will also be done if DSS takes custody and places the child with a relative.

Social Workers will explain to the foster placement all of the details as to what the child has been through. Social Workers will also explain all the items that will be taking place in the future

10B. If D.S.S. takes custody of the child and is not using a relative placement the foster placement will be decided at this time. Social Workers will explain to the foster placement all of the details as to what the child has been through. Social Workers will also explain all the items that will be taking place in the future.

11. *Watauga County Department of Social Services accepts all cases where children are alleged to be in homes with meth labs as abuse. As soon as possible Watauga County DSS will submit written notification to the District Attorney a report of abuse.*

12. *Other steps that will be taken are:*

- *All the child's belongings will be replaced to protect from repeated contamination.*
- *The child will receive counseling services either through Individual Counseling, Family Counseling, or Family Preservation. Determination of which or all of the services to be used will be made on a case-by-case basis.*
- *The parents involved in meth lab production with their children present will take part in a Meth Lab Hazard Training provided by the Watauga County Fire Marshal. This needs to be done prior to any Substance Abuse Assessment.*
- *The parents will be required whether they are incarcerated or not to take part in a complete Substance Abuse Evaluation and follow all recommendations. If possible it is preferred that there be A Family Substance Abuse Assessment that includes the children. Use of the Family Substance Abuse Assessment will be determined based on relationship between child and parent and age of the child.*
- *Parents will have to take part in drug screens at DSS request and at the Substance Abuse Treatment provider's request.*
- *Children age 3 and under will need to have Developmental Evaluations performed.*
- *The child will need a follow-up medical evaluation at or around 30 days from the initial evaluation that was completed. At this evaluation hair samples will be taken if urine screens were negative at the initial medical evaluation.*

Members of the response Team:

Watauga County Department of Social Services
Watauga County Sheriff's Department
New River Behavioral Health Care Substance Abuse Services
New River Behavioral Health Care Family Preservation *Watauga County Schools*
The Watauga County Developmental Evaluation Center
New River Behavioral Health Care PACT Program
Blue Ridge Pediatric Clinic *Northwestern Housing HUD*
Watauga County Office of Juvenile Justice
Watauga County Fire Marshal *Mountain Times Newspaper*
Watauga County District Attorney's Office
Watauga County Medical Center Emergency Room Staff
Watauga County Medical Center Infectious Disease Control
Watauga County EMS
Watauga County Health Department Early Childhood Intervention
Watauga County Health Department of Environmental Sciences
The Guardian ad Litem Program *Watauga County Foster Parents Representatives*
Forensic Toxicologist Dr. Andrew Mason

Appendix A-11 Schedules I & II
(As referenced in §18.2-248)

§ 54.1-3446. Schedule I. The controlled substances listed in this section are included in Schedule I:

1. Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:

Acetylmethadol; Allylprodine; Alphamethylfentanyl; Alphacetylmethadol (except levo-alphacetylmethadol, also known as levo-alpha-acetylmethadol, levomethadyl acetate, or LAAM); Alphameprodine; Alphamethadol;

Benzethidine; Betacetylmethadol; Betameprodine; Betamethadol; Betaprodine; Clonitazene; Dextromoramide; Diampromide; Diethylthiambutene; Difenoxin; Dimenoxadol; Dimepheptanol; Dimethylthiambutene; Dioxaphetylbutyrate; Dipipanone;

Ethylmethylthiambutene; Etonitazene; Etoxeridine; Furethidine; Hydroxypethidine; Ketobemidone; Levomoramide; Levophenacylmorphan; Morpheridine; Noracymethadol; Norlevorphanol; Normethadone; Norpipanone; Phenadoxone; Phenampromide; Phenomorphan; Phenoperidine; Piritramide; Proheptazine; Properidine; Propiram; Racemoramide; Trimeperidine.

2. Any of the following opium derivatives, their salts, isomers and salts of isomers, unless specifically excepted, whenever the existence of these salts, isomers and salts of isomers is possible within the specific chemical designation:

Acetorphine; Acetyldihydrocodeine; Benzylmorphine; Codeine methylbromide; Codeine-N-Oxide; Cyprenorphine; Desomorphine; Dihydromorphine; Drotebanol; Etorphine; Heroin; Hydromorphinol; Methyldesorphine; Methyldihydromorphine; Morphine methylbromide; Morphine methylsulfonate; Morphine-N-Oxide; Myrophine; Nicocodeine; Nicomorphine; Normorphine; Phoclodine; Thebacon.

3. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances, or which contains any of its salts, isomers, and salts of isomers, whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation (for purposes of this subdivision only, the term "isomer" includes the optical, position, and geometric isomers): Alpha-ethyltryptamine (some trade or other names: Monase;a-ethyl-1H-indole-3-ethanamine; 3-[2-aminobutyl] indole; a-ET; AET);

4-Bromo-2,5-dimethoxyphenethylamine (some trade or other names: 2-[4-bromo-2,5-dimethoxyphenyl]-1-aminoethane;alpha-desmethyl DOB;2C-B; Nexus);

3,4-methylenedioxy amphetamine; 5-methoxy-3,4-methylenedioxy amphetamine; 3,4,5-trimethoxy amphetamine; Bufotenine; Diethyltryptamine; Dimethyltryptamine; 4-methyl-2,5-dimethoxyamphetamine; 2,5-dimethoxy-4-ethylamphetamine (DOET);

Ibogaine; Lysergic acid diethylamide; Mescaline; Parahexyl (some trade or other names: 3-Hexyl-1-hydroxy-7, 8, 9, 10-tetrahydro-6, 6, 9-trimethyl-6H-dibenzo [b,d] pyran; Synhexyl); Peyote; N-ethyl-3-piperidyl benzilate; N-methyl-3-piperidyl benzilate; Psilocybin; Psilocyn; Tetrahydrocannabinols, except as present in marijuana and dronabinol in sesame oil and encapsulated in a soft gelatin capsule in a drug product approved by the U.S. Food and Drug Administration;

Hashish oil (some trade or other names: hash oil; liquid marijuana; liquid hashish); 2,5-dimethoxyamphetamine (some trade or other names: 2,5-dimethoxy-a-methylphenethylamine; 2,5-DMA); 3,4-methylenedioxymethamphetamine (MDMA), its optical, positional and geometric isomers, salts and salts of isomers; 3,4-methylenedioxy-N-ethylamphetamine (also known as N-ethyl-alpha-methyl-3,4 (methylenedioxy)phenethylamine, N-ethyl MDA, MDE, MDEA); 4-bromo-2,5-dimethoxyamphetamine (some trade or other names: 4-bromo-2,5-dimethoxy-a-methylphenethylamine; 4-bromo-2,5-DMA); 4-methoxyamphetamine (some trade or other names: 4-methoxy-a-methylphenethylamine; paramethoxyamphetamine; PMA); N-ethyl analog of phencyclidine; Pyrrolidine analog of phencyclidine; Thiophene analog of phencyclidine.

4. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers and salts of isomers whenever the existence of such salts, isomers and salts of isomers is possible within the specific chemical designation:

Gamma hydroxybutyric acid (some other names include GHB; gamma hydroxybutyrate; 4-hydroxybutyrate; 4-hydroxybutanoic acid; sodium oxybate; sodium oxybutyrate); Mecloqualone; Methaqualone.

5. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers and salts of isomers:

Aminorex (some trade or other names; aminoxaphen; 2-amino-5-phenyl-2-oxazoline; 4, 5-dihydro-5-phenyl-2-oxazolamine); Fenethylline; Ethylamphetamine; Cathinone (some trade or other names: 2-amino-1-phenyl-1-propanone, alpha-aminopropiophenone, 2-aminopropiophenone, norephedrone), and any plant material from which Cathinone may

be derived; Methcathinone (some other names: 2-(methylamino)-propiophenone; alpha-(methylamino) propiophenone; 2-(methylamino)-1-phenylpropan-1-one; alpha-N-methylaminopropiophenone; monomethylpropion; ephedrone; N-methylcathinone; methylcathinone; AL-464; AL-422; AL-463 and UR 1432).

6. Any material, compound, mixture or preparation containing any quantity of the following substances:

3-methylfentany-(N-[3-methyl-1-(2-phenyethyl)-4-piperidyl] N-phenylpropanamide), its optical and geometric isomers, salts, and salts of isomers; 1-methyl-4-phenyl-4-propionoxypiperidine (MPPP), its optical isomers, salts and salts of isomers; 1-(2-phenylethyl)-4-phenyl-4-acetyloxypiperidine (PEPAP), its optical isomers, salts and salts of isomers; N-[1-(1-methyl-2-phenyl)ethyl-4-piperidyl]-N-phenylacetamide (acetyl-alpha-methylfentanyl), its optical isomers, salts and salts of isomers; N-[1-(1-methyl-2-2-thienyl)ethyl-4 piperidyl]-N-phenylpropanamide (alpha-methylthiofentanyl), its optical isomers, salts and salts of isomers; N-[1-benzyl-4-piperidyl]-N-phenylpropanamide (benzylfentanyl), its optical isomers, salts and salts of isomers; N-[1-(2-hydroxy-2-phenyl) ethyl-4-piperidyl]-N-phenylpropanamide (beta-hydroxyfentanyl), its optical isomers, salts and salts of isomers; N-[3-methyl-1-(2-hydroxy-2-phenyl)ethyl-4-piperidyl]-N-phenylpropanamide (beta-hydroxy-3-methylfentanyl), its optical and geometric isomers, salts and salts of isomers; N-[3-methyl-1-(2-2-thienyl)ethyl-4-piperidyl]-N-phenylpropanamide (3-methylthiofentanyl), its optical and geometric isomers, salts and salts of isomers; N-[1-(2-thienyl)methyl-4-piperidyl]-N-phenylpropanamide(thenylfentanyl), its optical isomers, salts and salts of isomers; N-[1-(2-2-thienyl)ethyl-4-piperidyl]-N-phenylpropanimide(thiofentanyl), its optical isomers, salts and salts of isomers.

§ 54.1-3448. <u>Schedule II.</u>

The controlled substances listed in this section are included in Schedule II:

1. Any of the following substances, except those narcotic drugs listed in other schedules, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by combination of extraction and chemical synthesis:

Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, thebaine-derived butorphanol, dextrorphan, nalbuphine, nalmefene, naloxone naltrexone and their respective salts, but including the following:

Raw opium; Opium extracts; Opium fluid extracts; Powdered opium; Granulated opium; Tincture of opium; Codeine; Ethylmorphine; Etorphine hydrochloride; Hydrocodone; Hydromorphone; Metopon; Morphine; Oxycodone; Oxymorphone; Thebaine.

Any salt, compound, isomer, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in this subdivision, but not including the isoquinoline alkaloids of opium.

Opium poppy and poppy straw. Concentrate of poppy straw, the crude extract of poppy straw in either liquid, solid or powder form, which contains the phenanthrene alkaloids of the opium poppy.

Coca leaves and any salt, compound, derivative, or preparation of coca leaves, and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, but not including decocainized coca leaves or extractions which do not contain cocaine or ecgonine; cocaine or any salt or isomer thereof.

2. Any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, whenever the existence of these isomers, esters, ethers and salts is possible within the specific chemical designation:

Alfentanil; Alphaprodine; Anileridine; Bezitramide; Bulk dextropropoxyphene nondosage forms); Dihydrocodeine; Diphenoxylate; Fentanyl; Isomethadone; Levo-alphacetylmethadol (levo-alpha-acetylmethadol) (levomethadyl acetate) (LAAM); Levomethorphan; Levorphanol; Metazocine; Methadone; Methadone - Intermediate, 4-cyano-2-dimethylamino-4, 4-diphenyl butane; Moramide - Intermediate, 2-methyl-3-morpholino-1, 1-diphenyl-propane-carboxylicacid; Pethidine; Pethidine - Intermediate - A, 4-cyano-1-methyl-4-phenylpiperidine; Pethidine - Intermediate - B, ethyl-4-phenylpiperidine-4-carboxylate; Pethidine - Intermediate - C, 1-methyl-4-phenylpiperidine-4-carboxylic acid; Phenazocine; Piminodine; Racemethorphan; Racemorphan; Remifentanil.

3. Any material, compound, mixture or preparation which contains any quantity of the following substances having a potential for abuse associated with a stimulant effect on the central nervous system:

Amphetamine, its salts, optical isomers, and salts of its optical isomers; Phenmetrazine and its salts; Any substance which contains any quantity of methamphetamine, including its salts, isomers, and salts of isomers; Methylphenidate.

4. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

Amobarbital; Glutethimide; Secobarbital; Pentobarbital; Phencyclidine.

5. The following hallucinogenic substance: Nabilone.

6. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances which are immediate precursors to amphetamine and methamphetamine or phencyclidine:

Phenylacetone; 1-phenylcyclohexylamine; 1-piperidinocyclohexanecarbonitrile.